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Correspondence

Letters should not exceed 400 words and should be typed double spaced (including the references) and be signed by all authors

TO THE EDITOR, *Genitourinary Medicine*

Monoclonal antibodies in identifying *Neisseria gonorrhoeae*: cautionary note

Sir,

Many bacteriology laboratories identify isolates of *Neisseria gonorrhoeae* by the rapid carbohydrate utilisation test[1] and the Pharmacia Phadebact monoclonal GC test (Blomquist C *et al*, unpublished observation). The latter test recognises the serogroups WI and WII/WIII, which have epidemiological and clinical importance.

Since June 1985 we have examined 1509 consecutive isolates of *N gonorrhoeae*. Fifteen (nine from men and six from women) did not react with the Pharmacia monoclonal reagents. The first such isolate was noted in April 1986. These isolates were subjected to serovar analysis using two different sets of monoclonal coagglutination reagents, Genetic Systems (GS) and Pharmacia (Ph).[2] All 15 strains gave the same serological pattern, which corresponded to the serovar combination Bj/Bro (GS/Ph). In both analyses the upper case letter B corresponded to groups WII/WIII and the lower case letters represented positive reactions with the corresponding coagglutination reagents. Bj/Bro isolates are unusual in that they do not react with the Pharmacia monoclonal reagents; this serovar has been linked epidemiologically with Singapore.[3]

Contact tracing has shown links between eight of the patients. There was no obvious connection between the remaining seven patients, but all reported casual sexual contacts in the Glasgow area. There may therefore be further, as yet undetected, isolates with this serovar combination in this area. The index case has not been identified.

The manufacturers claim that the Phadebact monoclonal GC test identifies 99·7% of all isolates of *N gonorrhoeae*. In this study, 1% (15/1509) isolates did not react in the test. From our findings, we advocate caution in using only this test to confirm the identity of an isolate of *N gonorrhoeae*. Furthermore, we conclude from this small study that serovar analysis is a valuable and potentially useful tool in the microepidemiology of gonococcal infection. To date, however, the diversity and distribution of gonococcal serovar patterns has been established only in Edinburgh, where the occurrence of Bj/Bro isolates is rare.[4]

We thank Dr Hugh Young, Department of Bacteriology, University of Edinburgh for performing the serovar analysis.

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TO THE EDITOR, *Genitourinary Medicine*

How to maximise a limited chlamydial culture service

Sir,

Many departments of genitourinary medicine (GUM) in the United Kingdom still have only a limited chlamydial culture service, though the need for such a service was documented eight years ago.[1] We think that a complete chlamydial service is essential, but for clinics working within the constraints of a limited service we have tried to define criteria for making optimum use of chlamydial cultures.

A retrospective study in this department during a three month period showed 88 women, two men, and one child with conjunctivitis who all yielded chlamydiae. We looked further at the notes of the women a recorded the presenting symptoms of ea and of 100 controls who did not yi chlamydiae. Table 1 shows the results, whi confirmed the association of a high yield chlamydiae in the presence of ectopy, described by Burns *et al*.[2]

Table 1 *Numbers of women with ectopy c of 88 yielding chlamydiae (patients) and 1(controls*

	Patients:		*Controls:*	
Reason for attending	*No*	*No with ectopy*	*No*	*No with ectop*
Contacts with non-specific urethritis	31	23	18	4
Vaginal discharge	14	6	11	3
Abdominal pain	10	5	6	2
Contacts with gonorrhoea	9	7	1	1
Others	24	12	54	16

Table 2 shows the reasons that the patients attended the department. The m common reason for attending was associat with warts, but only two of these patie yielded chlamydiae.

On the basis of these findings we wo suggest that priority for testing should given to women with ectopy who are sex contacts of men with non-specific urethri (NSU), women with abdominal pain, sex contacts of men with gonorrhoea, a women with vaginal discharge. We real that sexual contacts of men with NSU a usually treated epidemiologically, and usi "valuable" chlamydial cultures may the fore be thought to be unnecessary, but defining a high risk group with a hi positive yield—namely, women with ecto who are sexual contacts of men with NSU these patients can be carefully followed up ensure microbiological cure. We would al add women patients whose sexual partn

Table 2 *Reasons that 88 women yielding chlamydiae attended GUM department*

Reason for attending	*No (%)*
Warts or contact with warts	21 (24)
Contacts with non-specific urethritis	18 (21)
Vaginal discharge	14 (16)
Pruritis vulvae	8 (9)
Abdominal pain	5 (6)
Other	22 (25)